



HEALTH INFORMATION

NAME (print): _____ DOB: _____

FORMER NAME: _____ PHONE: _____

ADDRESS: _____ CITY/STATE: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY:

- ADHD/ADD, AIDS/HIV, Anemia, Anxiety, Arthritis, Artificial Joints, Artificial Heart Valves, Asthma, Blood Disease, Breastfeeding, Cancer, Depression, Diabetes Type __, Dizziness, Ear Tubes, Epilepsy, Excessive Bleeding, Fainting, Glaucoma, Growths/Tumors, Hay Fever, Head Injuries, Heart Attack, Heart Disease, Heart Murmur, Hepatitis Type: __, Herpes, High Blood Pressure, HPV, Kidney Disease, Liver Disease, Mental Disorders, Neurological Disorder, Pacemaker, Pregnant, Due Date ____, Radiation Treatment, Recreational Drugs, Respiratory Problems, Rheumatic Fever, Rheumatism, Sinus Problems, Smoking, Vaping, Chew Tobacco, Stomach Problems, Stroke, Tuberculosis, Thyroid problems, Allergies: Codeine Allergy, Penicillin Allergy, Latex Allergy, Nickel Allergy, Local Anesthetic, Sulfa Drugs, Aspirin (NSAIDs), Other Allergies

Are you now under the care of a physician? Yes No
If yes, please explain _____

Are you taking any medications? Yes No
If yes, please list _____

Have you been admitted to a hospital or needed emergency care during the past two years Yes No
If yes, please explain _____

Do you have any health problems that need further clarification? Yes No
If yes, please explain _____

DENTAL INFORMATION

Date of Last Dental Visit _____ Date of X-Rays _____ Reason for Visit _____

How often do you brush your teeth? _____ How often do you floss? _____

- Do your gums bleed while brushing? Yes No
Do heat, cold, sweets or pressure cause you pain in your mouth? Yes No
Do you have clicking, popping or discomfort in your jaw? Yes No
Have you ever been instructed in the home care of your mouth? Yes No
Have you ever had any complications following dental treatment? Yes No

To the best of my knowledge, all of the above answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at my next appointment.

Print Name of Patient _____ Signature of Patient, or if minor, as applicable, Parent/Guardian/Loco Parentis _____ Date _____